

Massage Practitioner Expired Credential Reactivation Packet

Contents:

1. 676-102.... Contents List/SSN Information/Mailing Information 1 page
2. 676-103.... Application Instructions Checklist..... 1 page
3. 676-104.... Massage Practitioner Expired Credential Reactivation Application 3 pages
4. 676-097.... Certification of License and Examination 1 page

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Massage
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Board of Massage
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Application Instructions Checklist

You will be notified in writing if more documentation is needed. Please do not call to check on the status of an application. This will allow program staff to prepare your file for reactivation.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay Late Penalty Fee.**
- ☐ **Pay Current Renewal Fee.**
- ☐ **Pay Expired Credential Reissuance Fee.**
All fees are non-refundable. You can check the [fee page](#) for current fees.
- ☐ **#1 Demographic Information.**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change.

See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

- ☐ **#2 Previous Credentialing.** List **all** licenses you have held since last being licensed in Washington State. List in chronological order, most current first. Include your last active license in Washington State. If you need more space, attach a piece of paper.
- ☐ **#3 Professional Experience.** In chronological order, list all your professional work experience since your Washington State credential expired. If you need more space, attach a piece of paper.
- ☐ **#4 AIDS Education and Training Attestation.** Required by [WAC 246-12-040](#).
- ☐ **#5 Disciplinary Action Attestation.** Required by [WAC 246-12-040](#).
- ☐ **#6 Continuing Education Attestation.** Required by [WAC 246-12-040](#).
- ☐ **#7 Applicant's Attestation.** Required to be both signed and dated in order to process the application.

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Massage Practitioner Expired Credential Activation Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you read the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City

State

Country

Address

City State Zip County

Country

Phone () Fax () Cell ()

Email address

Mailing address (if different from above)

City State Zip County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

License # Issue Date

Validation Date Received

2. Previous Credentialing (Include Previous Credentials in Washington State)

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Nature of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Applicant's Initials

Date

5. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials

Date

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify I have met all continuing education and competency requirements for the past two (2) years. I am enclosing documentation on all classes attended/claimed.

Applicant's Initials

Date

7. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____ (city, state)
mm/dd/yyyy

By: _____
Signature of applicant

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Credential Verification

PART 1: Note to Applicant

Complete Part 1 and send it to the state(s) and/or jurisdiction(s) where you are or have been credentialed. Instruct them to send the form directly to the address listed above. Make a copy of this form if you are or have been credentialed in more than one state or jurisdiction. Credentialing agencies normally charge a fee to verify a credential. Check in advance to help expedite this process.

Name _____ Other names used _____

Mailing address _____

License Number _____ Date Issued _____
mm/yyyy

PART 2

Please complete this form about the applicant listed above. Submit the completed form and any other requested material directly to this office at the address above. We will not accept the form if sent by the applicant. Thank you.

Name of licensed practitioner: _____ Number of hours required: _____

Authority providing verification: (state, name & title) _____

Applicant licensed by:

Written Exam ☐ Name of Exam _____ Date _____ Score _____
mm/yyyy

Other Exam ☐ Name of Exam _____ Date _____ Score _____
mm/yyyy

Status of License/Certification/Registration: ☐ Current ☐ Not Current Expiration Date _____

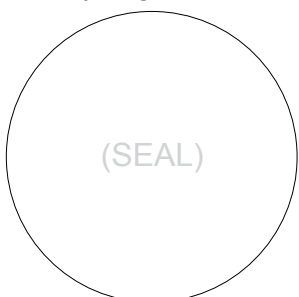
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If no, explain _____

Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No

Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No

If "yes", please provide a copy of the final order or other documentation of action taken.

If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No



Signature _____

Name _____

Title _____

Date _____
mm/dd/yyyy